STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175309	A. BUILDING _____ B. WING _____	C 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	**1711 N 4TH ST ARKANSAS CITY, KS 67005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citation represents the findings of complaint investigation #87967.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 55 residents, and identified 6 residents as elopement risks. Based on observation, record review and interviews, the facility failed to provide adequate supervision for 1 (#01) of the 3 sampled residents identified as elopement risks. Findings included: - The admission history, evidenced the facility admitted resident #01 on 3/27/15, and included the resident had a history of wandering away from home. The resident's spouse was not able to continue to care for the resident at home. The physician's admission record included diagnosis of Alzheimer's Disease (loss of memory, deterioration of intellectual functions) with behavior disturbances. The admission MDS (minimum data set), dated 4/3/15, identified the resident with a severe cognitive deficit, wandered daily, in need of limited assistance with all activities of daily living	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 needs. The care area assessments, dated 4/3/15 included: Cognition: BIMS (basic interview for mental status) reflected severe impairment of cognition with a score of 3. Behaviors: Exhibits wandering behaviors. He/she was ambulatory without the use of any kind of assistive devices and displayed wandering behaviors quite frequently throughout the facility. Nurses notes, from 3/27/15 through 4/28/15, revealed the first few days in the facility, staff documented the resident went to the facility exit doors and an electronic wanderguard bracelet was applied on the day of admission due to risk of elopement. After a few days the resident became less anxious. The care plan, dated 4/23/15 included, I have severely impaired cognition with a BIMS score of 3 second to my diagnosis of dementia with wandering. I ambulate independently most of the time without the use of any assistive devices. I sometimes need cueing/directions for where I need or want to be going. I have a behavior problem as evidenced by wandering and rejection of care related to my diagnosis of dementia with wandering. I have a wanderguard in place. Please check placement every shift and functioning every day and PRN (as needed). I like to stay busy some days. Please use any opportunity to involve me in an activity. I typically love to help.	F 323		

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F 323	Continued From page 2 Diversional activities include volunteer work activities such as cleaning tables, sweeping floors, wrapping potatoes, cooking and baking, folding napkins and towels and listening to music. On 7/13/15 at 11:30 A.M., administrative staff A explained resident #01 left the facility on 6/9/15 at approximately 3:40 P.M., when a group of visitors exited the building. The resident wore a wanderguard which sounded the alarm on the doors. The administrative assistant in the front foyer had stepped away from his/her computer and did not witness the resident leaving the facility with the group of visitors. On 7/8/15 at 6:09 P.M., dietary staff B, confirmed he/she was delivering food on carts to the nursing units, on 6/9/15 when an alarm sounded. There were 12-13 family members/visitors in the front entrance area leaving and staff B then turned off the alarm. Dietary staff B explained he/she thought they were all with the group of visitors, was the reason staff B turned off the alarm and went on delivering the foods. On 7/13/15 at 11:30 A.M., administrative staff A further explained the family members/visitors of another resident (the group leaving the facility) realized on 6/9/15, when they were were walking across the south lawn, they had an unknown male/female walking with them. The family members determined at that point to continue to walk to their house a couple of doors south and across the street from the facility. When they reached their home they assisted the resident in their car, drove him/her back to the facility entrance and escorted the resident into the building to the receptionist. The wanderguard system sounded properly when they reentered the facility.	F 323		

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F 323	Continued From page 3 On 6/15/15 administrative staff A completed an investigation of the elopement of the resident from the facility and had determined in the investigation that all alarms were functioning and sounding properly. The identified wandering exit seeking resident, left the facility with a group of visitors on 6/9/15 at approximately 3:40 P.M. A dietary staff member turned off the alarm without ensuring no residents were exiting the facility. The visitors recognized the resident as they walked to their home just south and across the street from the facility and returned the resident by car to the facility. The administrative investigation determined the resident was out of the facility without staff knowledge for approximately 10 to 15 minutes and returned without injury or discomfort. The facility elopement policy, dated 2/8/1999, included: If door alarms sound, staff would visual check inside and outside the area and/or exit triggering the alarm to determine the reason for the alarm. If the reason for the alarm could not be immediately identified, residents in the affected area will be accounted for, beginning with resident assessed at risk for an unwitnessed exit. The charge nurse would be responsible for coordinating this resident check and ensuring each resident accounted for. The facility failed to provide adequate supervision and assistive devices to prevent the resident from elopement from the facility without staff knowledge, when the staff member turned off the alarm without fully checking who exited the facility.	F 323		